Employee Waiver Form

Group Name: ____

MHP Group Number: _______________________ Group ID: ______________________

Please check the appropriate box below and provide all applicable information:

Employee Name: ____
(Please print)

I am eligible for group health coverage offered by this employer.

☐ I am currently enrolled in a group health program offered by this employer. The information for this coverage is as follows:

_______________________________ _______________________
Carrier Name Policy/Contract Number

Product Type: ☐ HMO ☐ POS ☐ PPO ☐ Traditional

I hereby waive MHP coverage offered by this employer for the following reason:

☐ I have my own individual coverage. The information for this coverage is as follows:

______________________________ ____________________________
Carrier Name Policy/Contract Number

☐ Please check this box if this employer provides any contribution or reimbursement for this coverage.

☐ I am covered under another group health plan not offered by this employer (spouse, self, parent, etc.). The information for this coverage is as follows:

_____________________________________ _____________________________
Carrier Name Policy/Contract Number

_____________________________________ _____________________________
Policyholder Name Relationship to Employee

☐ I was not offered health care coverage by this employer.

☐ I do not want the group health care coverage offered through this employer.
Explain: ____

The information printed above is true and accurate to the best of my knowledge.

Employee Signature Date